MEDI-CAL UPDATE Part 2
Billing and Policy
www.medi-cal.ca.gov

Medical Services • Obstetrics

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Contents

Digital Mammography and Computer Aided Detection Benefits

Effective for dates of service on or after December 1, 2006, the following HCPCS and CPT-4 codes are new Medi-Cal mammography benefits.

HCPCS Code	Description
G0202	Screening mammography, producing direct digital image, bilateral, all views
G0204	Diagnostic mammography, producing direct digital image, bilateral, all views
G0206	unilateral, all views

CPT-4 Code	Description
76083	Computer aided detection with further physician review for interpretation, with or without digitization of film radiographic images; screening mammography
76082	Computer aided detection with further physician review for interpretation, with or without digitization of film radiographic images; diagnostic mammography

Screening Mammography
Policy for screening mammography applies both to new and existing codes. Screening mammograms are restricted to females. The following age and frequency restrictions apply:

- Ages 34 years and younger - do not receive this benefit
- Ages 35 thru 39 - receive screening to establish a baseline; only one screening is reimbursable for women within this age range
- Ages 40 and older - restricted to one screening per year

Digital screening mammography (code G0202) and film screening mammography (codes 76083 and 76090 – 76092) will not be reimbursed in the same year by the same provider.

Diagnostic Mammography
Policy for diagnostic mammography applies both to new and existing codes. Diagnostic mammograms are reimbursable if one of the following applies:

- The recipient has distinct signs and symptoms for which a mammogram is indicated
- The recipient has a history of breast cancer
- The recipient is asymptomatic, but on the basis of the recipient's history and other significant factors in the physician's judgment, a diagnostic mammogram is indicated and appropriate

Please see **Digital Mammography**, *page 2*

Digital Mammography *(continued)*

ICD-9 Code Requirements
Claims submitted for diagnostic mammograms must include one of the following ICD-9 diagnosis codes. Claims without a diagnosis code will be denied.

ICD-9 Code	Description
174.0 – 174.9	Malignant neoplasm of female breast
175.0 – 175.9	of male breast
198.81	Secondary malignant neoplasm; breast
198.89	other
233.0	Carcinoma in situ of breast
238.3	Neoplasm of uncertain behavior; breast
239.3	Neoplasms of unspecified nature; breast
V10.3	Personal history of malignant neoplasm; breast
V16.3	Family history of malignant neoplasm; breast
V76.10 – V76.19	Special screening for malignant neoplasms; breast

CPT-4 Code 76499 Discontinued
Diagnostic mammograms are no longer reimbursable with CPT-4 code 76499 (unlisted diagnostic radiographic procedure).

Modifiers
When billing mammography with multiple views, providers must include the appropriate modifier(s) on the claim. For information about billing with modifiers, providers may refer to "Multiple Views" in the *Radiology: Diagnostic* section of the Part 2 provider manual.

This information is reflected on manual replacement page tar and non cd7 2 (Part 2).

HPV Vaccine is New VFC Benefit

Effective December 1, 2006, CPT-4 code 90649 (Human Papilloma virus [HPV] vaccine, types 6, 11, 16, 18 [quadrivalent], 3 dose schedule, for intramuscular use) is a new Vaccines For Children (VFC) benefit for female children ages 9 to 18.

The Food and Drug Administration (FDA) has approved Gardasil® for use in females 9 to 26 years to prevent cervical cancer caused by certain strains of HPV, as a three-dose regimen, injected at 0-, 2- and 6-month intervals.

Medi-Cal reimburses VFC providers an administrative fee for providing the Gardasil® injection. To receive reimbursement, providers must bill using code 90649 and modifier SL (state-supplied vaccine).

This information is reflected on manual replacement pages inject 30 (Part 2), inject vacc 1 (Part 2), modif used 4 (Part 2) and vaccine 3 and 6 (Part 2).

Abatacept is a New Medi-Cal Benefit

Effective December 1, 2006, abatacept (Orencia) is a Medi-Cal benefit, subject to prior authorization. Claims for abatacept must be billed with HCPCS code J3590 (unclassified biologics) and include an invoice for the drug. Abatacept is used for the treatment of moderate to severely active rheumatoid arthritis in recipients 18 years of age or older.

Treatment Authorization Requests (TARS) must include a diagnosis of ICD-9 code 714.0, 714.1 or 714.2, documentation that the patient is 18 years of age or older and documentation that the patient has had an inadequate response after treatment with the following:

- Two or more Disease-Modifying Anti-Rheumatic Drugs (DMARDs) and
- At least one of the tumor necrosis factor (TNF) antagonists (infliximab, etanercept or adalimumab) or the interleukin-1 receptor antagonist anakinra (inadequate response after at least one month of treatment)

Medical Considerations
Providers should consider the following when administering abatacept:

- It should not be used concurrently with TNF antagonists, anakinra or rituximab.
- It may be given as a monotherapy or with a DMARD.
- It is a pregnancy category C drug.
- A minimum of three months should occur between the administration of abatacept and the patient receiving a live virus vaccine.
- Patients with chronic obstructive pulmonary disease (COPD) may develop adverse reactions to abatacept, including COPD exacerbation.

This information is reflected on manual replacement pages inject 45 and 46 (Part 2) and inject list 2 (Part 2).

Corrected Effective Date for Enzyme Replacement Drugs Policy

Providers should note that the correct effective date for the most recent policy changes concerning laronidase, imiglucerase and agalsidase beta is for dates of service on or after April 1, 2006. An incorrect effective date appeared in the article "Enzyme Replacement Drugs Policy Update," published in the March 2006 *Medi-Cal Update*.

Claims with dates of service prior to April 1, 2006 for the above enzyme replacement drugs, using the updated policy, were correctly denied. Providers with such denied claims should send in new claims using the policy in effect prior to the publication of the article and manual replacement pages.

For more information on the policy changes, refer to the Part 2 manual, the *Injection* section, pages 57 and 58.

Oxygen and Related Equipment Policy Update

Legislation was signed July 12, 2006, amending *Welfare and Institutions Code*, Section 14105.48, specifying that effective for dates of service on or after January 1, 2007, reimbursement for oxygen delivery systems and oxygen contents shall utilize national HCPCS codes.

Therefore, effective for dates of service on or after January 1, 2007, the following coverage and reimbursement policy changes will be implemented:

Please see **Oxygen and Related Equipment**, *page 4*

Oxygen and Related Equipment *(continued)*

TAR Requirement
All requests for oxygen delivery systems, oxygen contents and related equipment will require a *Treatment Authorization Request* (TAR), which must be sent to the Fresno Medi-Cal Field Office. Authorization for oxygen therapy will be granted for the lowest cost delivery system that best meets the recipient's medical needs. Providers may need to request corrections to currently authorized TARs or submit new TARs for dates of service on or after January 1, 2007.

Reimbursement
Reimbursement rates for oxygen therapy services will be the lesser of the amount billed or 80 percent of the lowest maximum allowance of the California Medicare reimbursement rate for the same or similar item or service. Rates will be adjusted for the following HCPCS codes: A4615, A4620, E0424, E0425, E0430, E0441, E0442, E1353 and E1355.

Procedure Codes
The following HCPCS Level II oxygen delivery systems and oxygen contents procedure codes will be new benefits covered by Medi-Cal:

E0439, E0440, E0443, E0444 and E1392*

* This code will be activated with the 2006 HCPCS annual update effective for dates or service on or after November 1, 2006.

The descriptors for the following currently covered HCPCS Level II oxygen delivery system and oxygen contents procedure codes will be revised from local descriptors to national descriptors. Policy will be revised accordingly:

E0424, E0441 and E0442

All other currently covered benefits will remain in effect.

"One Unit of Oxygen" Redefined
One unit of oxygen equals "one month's supply," regardless of how many pounds or cubic feet of oxygen are supplied. This change in the definition of "one unit of oxygen" affects codes E0441, E0442, E0443 and E0444.

Modifiers
The following three new HCPCS Level II modifiers are to be used only with stationary gaseous (E0424) or liquid (E0439) systems or with a non-portable oxygen concentrator (E1390, E1391). These modifiers are not reimbursable with any other codes.

QE Prescribed amount of oxygen is less than one liter per minute (LPM). The reimbursement amount is reduced by 50 percent.

QF Prescribed amount of oxygen is greater than four liters per minute and portable oxygen is also prescribed. The reimbursement amount is increased by 50 percent.

QG Prescribed amount of oxygen is greater than four liters per minute and portable oxygen is not prescribed. The reimbursement amount is increased by 50 percent.

Criteria
Medi-Cal covers oxygen therapy for recipients who meet the established medical criteria. The requirements for establishing the medical necessity for oxygen are listed below.

A. Laboratory evidence of hypoxemia in the chronic stable state or exercise induced hypoxemia **and a prescription** from the recipient's physician specifying all of the following information must be submitted with the request for prior authorization:

1. The diagnosis or medical condition requiring supplemental oxygen
2. The oxygen flow rate requested
3. An estimate of the frequency (hours per day) and duration of use (months)

A prescription for "Oxygen prn" or "Oxygen as needed" is unacceptable.

Please see **Oxygen and Related Equipment**, *page 5*

Oxygen and Related Equipment *(continued)*

Initial requests for oxygen must include a recent arterial blood gas (ABG) report (obtained within 30 days of the request), unless the recipient is unable to tolerate the test in which case an oximetry study is satisfactory. However, documentation from a physician must be submitted explaining the rationale for submission of an oximetry study instead of an ABG.

Supplemental oxygen requests require that the recipient's arterial partial pressure of oxygen (Pa_{02}) must be 55 mm Hg or less, or the oxygen saturation (Sa_{02}) must be 88 percent or less with the test taken on room air in the chronic stable state and, if hospitalized, no more than two days prior to hospital discharge.

If the arterial Pa_{02} is 56-59 mm Hg or the Sa_{02} is 89 percent, a secondary diagnosis is necessary, such as but not limited to: congestive heart failure, cor pulmonale or erythrocytosis/erythrocythemia. Medi-Cal Field Office consultants who are reviewing the medical necessity for supplemental oxygen use will take into consideration that the laboratory specified values above may vary due to factors such as a recipient's age, or the altitude level at which the test was taken.

If the arterial Pa_{02} is equal to or greater than 60 mm Hg or the Sa_{02} is equal to or greater than 90 percent, the medical necessity for oxygen is unlikely to be established. However, individual cases submitted with detailed documentation substantiating medical necessity will be evaluated on a case-by-case basis.

For pediatric recipients an oximetry study with Sa_{02} submitted with the TAR is satisfactory. No ABG is required. Requests for supplemental oxygen for pediatric recipients with a Sa_{02} of 90 mm Hg or greater will be considered on a case-by-case basis. Requests for supplemental oxygen for children with medical conditions covered by California Children's Services (CCS) should be submitted to the appropriate CCS county office for approval.

B. A stationary oxygen system will be authorized unless the recipient's need to pursue usual activities with a portable oxygen system is established with the submitted documentation.

C. If the recipient's need for supplemental oxygen changes, the recipient's physician must update the medical documentation and laboratory evidence accordingly, and the oxygen and related equipment provider must submit the new data with a new TAR.

D. If the supplemental oxygen system requested is not the lowest cost system which will meet the recipient's medical needs, Medi-Cal will modify the request. If oxygen is used for less than 24 hours per day, Medi-Cal may pro-rate the reimbursement to reflect less than 24 hours per day utilization of oxygen. If there is medical necessity which justifies a recipient's use of a higher cost supplemental oxygen system, it must be documented in detail by the prescribing physician. If a higher cost system is requested only for the recipient's and/or provider's convenience, the TAR may be authorized but reimbursement will be at the rate of the lowest cost item.

E. If a patient qualifies for additional payment for greater than four LPM and also meets the requirements for portable oxygen (E0431 or E0434), payment will be made for either the stationary system (at the higher allowance) or the portable system (at the standard fee schedule allowance for a portable system), but not both. In this situation, if both a stationary system and a portable system are billed for the same rental month, the portable oxygen system will be denied.

F. Monthly rental and reimbursement for purchased oxygen concentrators (E1390, E1391 and E1392) include all accessories, delivery and set-up. A portable gaseous system may be added if there is a documented need for mobility or exercise.

G. After one year of oxygen therapy, re-certification is required for continued use. The request must include a recent ABG report (obtained within 30 days of the request), unless the recipient is unable to tolerate the test in which case an oximetry study is satisfactory. However, documentation from a physician must be submitted explaining the rationale for submission of an oximetry study instead of an ABG.

More information will appear in a future *Medi-Cal Update.*

Flow Cytometry Code Policy Reminder

Effective retroactively for dates of service on or after November 1, 2005, CPT-4 code 88182 (flow cytometry, cell cycle or DNA analysis) is added as a Medi-Cal benefit.

Also effective retroactively for dates of service on or after November 1, 2005, the following flow cytometry codes have been assigned specific prices.

Codes 88184 and 88145 must be billed with modifier TC (technical component). Codes 88187, 88188 and 88189 must be billed with modifier 26 (professional component).

The full descriptions and maximum reimbursement for the codes are as follows:

CPT-4 Code	Description	Medi-Cal Rate
88182	Flow cytometry, cell cycle or DNA analysis	$88.27
88184	Flow cytometry cell surface, cytoplasmic, or nuclear marker, technical component only; first marker	$42.18
88185	each additional marker	$20.68
88187	Flow cytometry, interpretation; 2 to 8 markers	$55.98
88188	9 to 15 markers	$69.84
88189	16 or more markers	$92.02

No action is required on the part of providers. Claims submitted with these codes for dates of service beyond the six-month billing limit must include delay reason code "11" in the *COB (Delay Reason)* field (Box 24J) and documentation justifying the delay.

Morphometric Analysis Pricing Update

Effective retroactively for dates of service on or after November 1, 2005, CPT-4 codes 88367 and 88368 are Medi-Cal benefits. Also for the same dates of service, codes 88360, 88361, 88367 and 88368 have been assigned a specific price. No action is required on the part of providers. Claims submitted with these codes for dates of service beyond the six-month billing limit must include delay reason code "11" in the *COB (Delay Reason)* field (Box 24J) and documentation justifying the delay.

The full descriptions and prices for the codes are as follows:

CPT-4 Code	Description	Medi-Cal Rate
88360	Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semi-quantitative, each antibody; manual	$90.06
88361	using computer-assisted technology	$136.67
88367	Morphometric analysis, in situ hybridization, (quantitative or semi-quantitative) each probe; using computer-assisted technology	$169.79
88368	manual	$120.09

Codes 88360 and 88361 cannot be billed with code 88342 (immunochemistry [including tissue immunoperoxidase], each antibody) unless each procedure is for a different antibody for the same recipient, same provider and date of service. Providers must document the different antibody in the *Reserved For Local Use* field (Box 19) of the claim or on an attachment.

Provider Orientation and Update Sessions

Medi-Cal providers seeking enrollment in the Family PACT (Planning, Access, Care and Treatment) Program are required to attend a Provider Orientation and Update Session. The dates for upcoming sessions are listed below.

Individual and group providers wishing to enroll must send a physician-owner to the session. Clinics wishing to enroll must send the medical director or clinician responsible for oversight of medical services rendered in connection with the Medi-Cal provider number.

Office staff members, such as clinic managers, billing supervisors and patient eligibility enrollment supervisors, are encouraged to attend but are not eligible to receive a *Certificate of Attendance*. Currently enrolled clinicians and staff are encouraged to attend to remain current with program policies and services. Medi-Cal laboratory and pharmacy providers are automatically eligible to participate in the Family PACT Program without attending an orientation session.

The session covers Family PACT provider enrollment and responsibilities, client eligibility and enrollment, special scope of client services and benefits, provider resources and client education materials. This is not a billing seminar.

Please note the upcoming Provider Orientation and Update Sessions below.

Palm Springs

December 11, 2006
8:30 am – 4:30 pm

SPA Resort in Palm Springs
100 North Indian Canyon Drive
Palm Springs, CA 92262
(760) 883-1000

Fresno

February 22, 2007
8:30 am – 4:30 pm

Picadilly Inn – West Shaw Hotel
2305 West Shaw Avenue
Fresno, CA 93711
(559) 226-3850

San Bernardino

April 12, 2007
8:30 am – 4:30 pm

Clarion Hotel & Convention Center
295 North E Street
San Bernardino, CA 92401
(909) 381-6181

For a map and directions for these locations, go to the Family PACT Web site (**www.familypact.org**) and click "Providers" at the top of the home page, then "Provider Training," and finally, click the appropriate location. In the "Provider Orientation & Update Session" document, click the "For directions: click here" link.

Registration

To register for an orientation and update session, go to the Family PACT Web site (**www.familypact.org**) and click "Providers" at the top of the home page, then "Provider Training," and finally, click the "Registration" link next to the appropriate date and location and print a copy of the registration form.

Fill out the form and fax it to the Office of Family Planning, ATTN: Darleen Kinner, at (916) 650-0468. If you do not have Internet access, you may request the registration form by calling 1-877-FAMPACT (1-877-326-7228).

Providers must supply the following when registering:

- Name of the Medi-Cal provider or facility
- Medi-Cal provider number
- Contact telephone number
- Anticipated number of people attending

Please see **Provider Orientation**, *page 8*

Provider Orientation *(continued)*

Check-In
Check-in begins at 8 a.m. All orientation sessions start promptly at 8:30 a.m. and end by 4:30 p.m. At the session, providers must present the following:

- Medi-Cal provider number
- Medical license number
- Photo identification

Note: Individuals representing a clinic or physician group should use the clinic or group Medi-Cal provider number, not an individual provider number or license number.

Certificate of Attendance
Upon completion of the orientation session, each prospective new Family PACT medical provider is mailed a *Certificate of Attendance*. Providers should include the original copy of the *Certificate of Attendance* when submitting the Family PACT application and agreement forms (available at the session) to Provider Enrollment Services. Providers arriving late or leaving early will not be mailed a *Certificate of Attendance*. Currently enrolled Family PACT providers do not receive a certificate.

Contact Information
For more information about the Family PACT Program, please call 1-877-FAMPACT (1-877-326-7228) or visit the Family PACT Web site at **www.familypact.org**.

The Family PACT Program was established in January 1997 to expand access to comprehensive family planning services for low-income California residents.

Medi-Cal List of Contract Drugs

The following provider manual sections have been updated: *Drugs: Contract Drugs List Part 1 – Prescription Drugs, Drugs: Contract Drugs List Part 2 – Over-the-Counter Drugs* and *Drugs: Contract Drugs List Part 4 – Therapeutic Classifications Drugs.*

Additions, effective November 1, 2006

Drug	Size and/or Strength
* ASPIRIN/EXTENDED-RELEASE DIPYRIDAMOLE	
Capsules	25/200 mg
* Restricted to use in individuals who have had transient ischemia of the brain and have failed on aspirin therapy, or completed ischemic stroke due to thrombosis.	
RAMELTEON	
* Tablets	8 mg
* Restricted to a maximum dispensing quantity of thirty (30) tablets and a maximum of three (3) dispensings in any seventy-five (75) day period.	

Changes, effective November 1, 2006

Drug	Size and/or Strength
* ETANERCEPT	
Injection kit	25 mg
Injection, prefilled syringe	50 mg/0.98 cc
Injection, SURECLICK syringe	**50 mg/0.98 cc**
* Preferred prior authorization injectable biologic response modifier ~~for the treatment of rheumatoid arthritis.~~	

Please see **Contract Drugs**, *page 9*

Contract Drugs *(continued)*

Changes, effective November 1, 2006 (continued)

Drug	**Size and/or Strength**	
MORPHINE SULFATE		
Injection		
* Capsules, extended release	30 mg	
	60 mg	
	90 mg	
	120 mg	
* Restricted to a maximum of 90 capsules per dispensing and a maximum of three dispensings of any strength in a 75-day period for claims submitted with dates of service from December 1, 2003, through September 30, 2005.		
* Capsules, sustained release	20 mg	
	30 mg	
	50 mg	
	60 mg	
	100 mg	
* Restricted to a maximum of 90 capsules per dispensing and a maximum of three dispensings of any strength in a 75-day period. Exceptions to this restriction require prior authorization. (NDC labeler code 63857 [Faulding Laboratories **or Alpharma Branded Products Division, Inc.**] only.)		
	10 mg	
* Tablets	15 mg	
	30 mg	
* Restricted to a maximum of 90 capsules per dispensing and a maximum of three dispensings of any strength in a 75-day period. Exceptions to this restriction require prior authorization.		
* OXICONAZOLE NITRATE		
Cream	1 %	15 Gm
		30 Gm
		60 Gm
* Restricted to claims submitted with dates of service through March 31, 2006.		
Lotion	1 %	30 cc
***** ~~Restricted to claims submitted from May 1, 2000 through March 31, 2006.~~		
*** (NDC labeler code 00462 [PHARMADERM].**		

Please see **Contract Drugs**, *page 10*

Contract Drugs *(continued)*

Changes, effective January 1, 2006

Drug	**Size and/or Strength**	
* FLUCONAZOLE		
Injection		
	2 mg/cc	100 cc (saline) 200 cc (saline) 100 cc (dextrose) 200 cc (dextrose)
Tablets	50 mg 100 mg 150 mg 200 mg	
* Restricted to use in cancer patients and in patients with Human Immunodeficiency Virus (HIV) infection.		
(NDC labeler code 00049 [Pfizer-Roerig or Pfizer Inc.] injection and 150 mg tablets only.)		

Instructions for Manual Replacement Pages — Part 2

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Remove and replace at the end of the *California Children's Services (CCS) Billing Overview* section:	*CCS Program Billing Guidelines* 1/2 *
Remove:	cal child sar 7 thru 9
Insert:	cal child sar 7/8 *
Remove and replace:	cal child ser 1/2 *
Insert:	cal child ser 23 *
Remove and replace:	forms leg 3/4 * hcpcs 1/2 * hyst 5/6 * inject 29/30, 45 thru 48 inject list 1/2 inject vacc 1 medi non cpt 1 * modif used 3 thru 6 *, 7/8
Remove:	radi dia 23 thru 27
Insert:	radi dia 23 thru 28 *
Remove and replace:	tar and non cd7 1/2 vaccine 3 thru 8

* Pages updated due to ongoing provider manual revisions.